Section: Obstetrics and Gynaecology

Original Research Article

A CROSS SECTIONAL STUDY OF PERINATAL OUTCOME IN MULTIPLE GESTATIONS IN RELATION TO CHORIONICITY

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ABSTRACT

Background: Multiple pregnancies are linked to higher maternal and foetal risk; as a result, they need special consideration. The purpose of this study was to assess the perinatal outcome and pregnancy problems in twin pregnancies. **Materials and Methods:** From November 2022 to October 2023, a cross-sectional study was conducted on all twin births at the Tertiary Care Hospital, Tamilnadu. There were 126 births of twins. Analysis was done on maternal information, prenatal problems, and foetal outcome. **Result:** The age range of 20 to 29 years and multigravida had the highest prevalence of twin pregnancies at 2.09%. The most frequent foetal presentation was vertex-vertex. The most common delivery method was a caesarean section (76.6%). The most frequent maternal consequence was preterm labour (75%), which was followed by anaemia (60%). Birth hypoxia (35%), intrauterine growth restriction (13.3%), hyperbilirubinemia (10%), and newborn sepsis (3.3%) were perinatal complications. The LBW status of the newborns was 85%. In our study, perinatal mortality was 15%. **Conclusion:** Improved mother and newborn outcomes in twin pregnancies will result from the utilisation of antenatal care services, the detection and anticipation of problems, intrapartum management, and appropriate NICU facilities.

INTRODUCTION

Multiple Pregnancies have been celebrated throughout human evolution. They range from its central role in mythology with the founding of Rome by Romulus and Remus, to the astrological twin twins, to the biblical account of Rebekah giving birth to Esau and Jacob in Genesis, to the central figure of our culture. Appears on all sides. Twelfth Night and the Comedy of Errors, inspired by Shakespeare's own twin daughters. Seems to be occurring. The apple in half isn't a twin, just like his two creatures. Who is Sebastian?" (Twelfth Night, Act 5, sc. 1, l. 223-4.). So it's perhaps not surprising that this glorification of the twin has entered the realm of infertility. Most recently, a widely cited study by Gleicher and colleagues reported that 45% of women had one. A belief reflected in studies reporting the apparent strong desire of couples to have twins, leading to studies in which twin pregnancies rate as highly or highly desirable.

Multiple pregnancies have increased in recent decades. The use of drugs to induce ovulation, in vitro fertilization, and increasing maternal age at conception are two major factors in the increased incidence. Negative perinatal effects: The main problems encountered in multiple pregnancies are prematurity, low birth weight, intrauterine growth retardation, birth trauma, birth asphyxia, congenital anomalies and fetal complications inherent in twin pregnancies. About a quarter of twins require neonatal hospitalization (NICU). Until the last decades of the 20th century, twins were relatively rare, with only 7.44 per 1,000 births in Britain in 1938. This was the first year to distinguish mothers with multiple births documented. The number of multiple births has increased significantly over the decades. According to the latest statistics available from the United States, the twin birth rate increased by 2% in 2004 to 32.2 per 1,000 total births. Although the birth rate of triplets or more decreased by 6% for him, the number increased sharply in his 1980s and his 1990s and is still at 1.8 per 1,000 live births. The United Kingdom (UK) has a much lower twin rate, just 10.5 twins per 1,000 live births in 2005, but here too the twin rate continues to rise, from 14.1 per 1,000 live births in 1995 to 14.9 per 1,000 live births in 2005.This study introduction examines some of the reasons for this increase and whether it should be considered cause for concern. Twins have five times the risk of dying before the age of one year compared to singleton pregnancies. A mother with a twin

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pregnancy has a 3.1% risk of being transferred to an intensive care unit, but for singleton pregnancies, it is only 0.3%.

Aims and Objectives

1. To study the perinatal morbidity and mortality in multiple gestation in relation to chorionicity, causes for adverse perinatal outcome
2. To study the number of babies discharged without risk factors
3. To analyse the complications of monochrionic and dichorionic twin gestation

MATERIALS AND METHODS

Inclusion Criteria

Patients with multiple Pregnancy attending Tertiary Care Hospital of more than 28 weeks of gestation.

Exclusion Criteria

Patients with gestational age less than 28weeks.

RESULTS

Chorionicity: Majority of the patients were Monochorionic diamniotic with 62 cases (49.2%), while 59 cases were dichorionic diamniotic (46.8%). Only 3 cases were Monochorionic monoamniotic (2.38%) and 2 cases were Trichorionic triamniotic. In our study, Monochorionic gestation had higher incidence [51.9%] compared to dichorionic [46.8%] and trichorionic [1.58%] gestations. [Table 1].

Age and Chorionicity: Most of the patients in our study belonged to the age group of 25-30 years with 98 cases (77.7%)out of which 47 [37.3%] were dichorionic and 51were monochorionic [40.4%]. Second common being more than 30 years with 14 patients (11.1%), out of which 6 were dichorionic,7 monochorionic and 1 trichorionic gestation. Next we have 20-24 years with 11 cases (8.73%) out of which 4 were dichorionic, 6 monochorionic and 1 was trichorionic. Least common oneless than 20 years with 3 cases (2.42%), out of which 2were dichorionic and only one monochorionic. In our study, Multiple pregnancies occurred most commonly in the age group of 25-30 years with monochorionic gestation with higher incidence [40.4%] compared to dichorionic [37.3%] and trichorionic [0%] gestation. [Table 2]

Table 1

Chorionicity	No. of Cases (N)	Percentage (%)
DCDA	59	46.8%
MCDA	62	49.2%
MCMA	3	2.38%
TCTA	2	1.58%
Grand Total	126	100.00%

Table 2

Age Group	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
<20	1	2	0	3	2.38%
20-24	6	4	1	11	8.73%
25-30	51	47	0	98	77.7%
>30	7	6	1	14	11.1%
Grand Total	65	59	2	126	100%

Parity and Chorionicity: 45 of the primi and 20 of the multi gravida had monochorionic gestation, 38 of primi and 21 of multigravida had dichorionic gestation and 2 primi had trichorionic gestation. In our study, the incidence of Multiple pregnancy is higher in Primi gravid [67.4%] than in multi gravid [32.5%]. [Table 3]

Family History and Chorionicity: Only 7 had family history of multiple gestation, out of which 5 had dichorionicity and only 2 with monochorionicity. In our study, Family history showed no significance in multiple pregnancy**.** [Table 4]

Table 3

Family History	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
Present	2	5	0	7	5.56%
Absent	63	54	2	119	94.44%
GrandTotal	65	59	2	126	100%

Mode of Conception and Chorionicity: Majority of the patients had only spontaneous conception with 118 patients (93.6%) In vitro fertilization done in 7 patients (5.55%), In spontaneous conception, 56 were dichorionic, 61 were monochorionic and 2 were trichorionic. Ovulation induction done in one patient that too monochorionic [0.79%]. In our study, majority of multiple pregnancies were of spontaneous conception [93.6%] than Assisted Reproductive techniques. [Table 5]

Table 4

Mode Of Conception	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
Ivf	3	3	1	7	5.55%

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Ovulationinduction	1	0	0	1	0.79%
Spontaneous	61	56	1	118	93.6%
Grandtotal	65	59	2	126	100%

Gestationalageat delivery and Chorionicity: Majority of the pregnant women were delivered at the gestational age of 33-36 weeks with 75 cases (59.52%), out of which 32 [42.6%] were dichorionic and 43 were monochorionic [57.3%]. Second common being 30-32 weeks with 29 cases (23.01%) out of which 9 were dichorionic, 18 were monochorionic and 2 were trichorionic [1.58%]. third common being more than 36 weeks with 21 cases (16.6%)out of which18 were dichorionic and 3 were monochorionic. Only one patient had gestational age of less than 30 weeks (0.79%) which had monochorionicity. [Table 6]

Table 5

Gestational Age	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
<30	1	0	0	1	0.79%
30-32	18	9	2	29	23.01%
33-36	43	32	0	75	59.52%
>36	3	18	0	21	16.6%
Grand Total	65	59	2	126	100%

In our study, most of the multiple pregnancies were delivered preterm [83.3%] than term [16.7%] with higher rates in monochorionic [59%] than dichorionic [395] and trichorionic [1.95] gestation.

Maternal High Risk and Chorionicity: Most of the patients had no high yield risk for pregnancy (74 patients -58.7%), while only 21 patients had Gestational hypertension with (16.6%) out of which 5 of them were dichorionic, 15 of them were monochorionic and 1 was trichorionic. Anemia in 10 cases (7.9%)out of which 5 were dichorionic,4 were monochorionic and 1 was trichorionic. Oligohydromnios in 7 patients (5.55%), out of which only one was dichorionic and 6 were monochorionic. Gestational diabetes in 4 cases (3.17%)out of which 3 of them were dichorionic and one of them with monochorionicity. Pre-Eclampsia were seen in 3 out of which 1 of them was dichorionic and 2 of them were monochorionic and 2 cases were placenta previa out of which both of them were dichorionic. One patient each had Severe pre-eclampsia, Thrombocytopenia and polyhydramnios (0.79%) and all of them were monochorionic. Hence, in our study, the most common co-morbidity is GHTN [16.6%] with 11.9% in monochorionic,3.9% in dichorionic and 0.79% in trichorionic gestation. Nexttothatis Anemia [7.9%] with 3.9% indichorionic, 3.17% inmonochorionic and 0.79% in trichorionic gestation. Hence, in our study, GHTN being more prevalent in monochorionicity and Anaemia being more prevalent in dichorionicity. [Table 7]

Table 6

Maternal High Risk	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
Anemia	4	5	1	10	7.9%
Gdm	1	3	0	4	3.17%
Ghtn	15	5	1	21	16.6%
Idm	0	1	0	1	0.79%
Oligohydromnios	6	1	0	7	5.55%
Overtdm	1	0	0	1	0.79%
Placentaprevia	0	2	0	2	1.58%
Preeclampsia	2	1	0	3	2.38%
Severepreeclampsia	1	0	0	1	0.79%
Thrombocytopenia	1	0	0	1	0.79%
Polyhydromnios	1	0	0	1	0.79%
Nil	33	41	0	74	58.7%
GrandTotal	65	59	2	126	100%

Mode of Delivery and Chorionicity: Majority of The patients had labour natural is with 63 patients (50%), out of which 31 were dichorionic, 31 were monochorionic and 1 was trichorionic. 61 cases under went LSCS, out of which 26 were dichorionic,34 were monochorionic and 1 was trichorionic. Vaccum delivery and Outlet forceps delivery were only one case each and both were dichorionic. In our study, LN rates were higher [50%] compared to LSCS [48.4%] and monochorionic gestation had higher rates of LSCS [55.7%] than dichorionic [42.6%] and trichorionic[1.6%] [Table 8]

Table 7

Mode of Delivery	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
LN	31	31	1	63	50%

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LSCS	34	26	1	61	48.4%
Outlet Forceps	0	1	0	1	0.79%
Vacuum Delivery	0	1	0	1	0.79%
Grand Total	65	59	2	126	100%

Presentation and Chorionicity: Vetex-vertex was the commonest presentation with 96 cases (76.1%) out of which 44 were dichorionic and 52 were monochorionic. Breech presentation the least common with only one patient (0.79%), that too monochorionic. In trichorionic gestation, Vx-Vx-Breech was the presentation in 1 case and theother case had Breech-Breech-Vertex as the presentation. [Table 9]

Table 8

Presentation	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
Breech	1	0	0	1	0.79%
Breech-breech	1	1	0	2	1.58%
Breech-Vx	1	6	0	7	5.55%
Transverselie/Vx	1	1	0	2	1.58%
Vx-breech	9	7	0	16	12.6%
Vx-Vx	52	44	0	96	76.1%
Vx-Vx-breech	0	0	1	1	0.79%
Breech-breech-Vx	0	0	1	1	0.79%
Grand Total	65	59	2	126	100%

Indication for Lscs and Chorionicity: The commonest indication for LSCS in our study was Previous LSCS with CPD in 23cases [37.7%], out of which 13 were dichorionic [21.3%] and 10 were monochorionic [16.3%] Second common indication being fetal distress with 16 cases [26.2%], outof which 14 were monochorionic [22.9%] and 2 were dichorionic [3.2%] Third common indication wasCephalopelvic disproportion seen with 8 [13.1%] cases out ofwhich 5 [8.11%] were dichorionic and 3 were monochorionic [4.9%]

Fourth common indication was first twin breech seen among four patients only, out of which 3 were dichorionic and only one was monochorionic. Abruption [1.63%], severe oligohydromnios [1.63%], Twin 2 anomalous baby [1.63%] were indications for LSCS with one case each in Monochorionic twins. MCMA twins was indication for LSCSin 2 cases [3.27%] of monochorionic twins. Two patients under went LSCS as Twin 1 Transverse lie as an indication [3.27%] with 1 case each in Monochorionic and dichorionic twins. Placenta Previa[1.63%] was an indication for Caesarean for 1 casein dichorionic twins.1 case of trichorionic gestation[1.63%] underwent LSCSas First triplet breech as an indication.[Table 10].

Table 9

Indication For LSCS	Chorionicity			Grand Total	Percentage
	Monochorionic	Dichorionic	Trichorionic		
Abruption	1	0	0	1	1.64%
CPD	3	5	0	8	13.11%
Fetal distress	14	2	0	16	26.23%
First twin breech	1	3	0	4	6.56%
MCMA twins	2	0	0	2	3.28%
Placenta previa	0	1	0	1	1.64%
PPROM/breech	0	1	0	1	1.64%
Previous2LSCSinlabour	0	1	0	1	1.64%
Previous LSCS/CPD	7	10	0	17	27.87%
Previous LSCS/breech	1	0	0	1	1.64%
In labour					
Previous LSCS/PPROM/CPD	1	2	0	3	4.92%
Previous LSCS/precious baby/CPD	1	0	0	1	1.64%
Severe oligohydromnios	1	0	0	1	1.64%
Twin1transverselie	1	1	0	2	3.28%
Twin2 anomalous baby	1	0	0	1	1.64%
1sttriplet breech	0	0	1	1	1.64%
Grand Total	34	26	1	61	100%

In our study, Fetal distress [26.2%] as an indication for LSCS was in higher incidence in monochorionicity [22.9%] than in dichorionicity [3.2%] and trichorionicity [0%].

DISCUSSION

In my study, we have analysed Perinatal outcome in multiple pregnancy in relation to chorionicity. Multiple pregnancies constitutes an important portion of high risk pregnancies attending any obstetric health care facility.[1,2]

As per [Table 2], Most of the patients in our study belonged to the age group of 25-30 years with 98 cases (77.7%), the second common being more than 30 years with 14 patients (11.1%), next we have 20-24 years with 11 cases (8.73%) and least common one is less than 20 years with 3 cases (2. 42%).Thus,

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multiple Pregnancies occured in higher numbers in the age group of 25-30years with monochorionic gestation at higher rate than dichorionic gestation [37.3%] and trichorionic gestation. The monochorionic gestation found to be increasing as the age advances.

By analyzing gestational age at delivery, majority of the pregnant women in our study [Table 6] were delivered at the gestational age of 33-36 weeks with 75 cases (59.52%), with higher rate of delivery in monochorionic gestation [57.3%], second common being 30-32 weeks with 29 cases (23.07%) and third common being more than 36 weeks with 21 cases (16.6%). Majority of cases were delivered at the moderate Preterm period in both monochorionic [57.3%] and dichorionic gestation [37.3%]. The trichorionic pregnancies [1.58%] were delivered at 30-32 weeks.

As per the incidence of preterm deliveries [83.3%]in the current study was higher as compared to Chowdhury et al (44%).However, the incidence reported by Bangalet al was much higher (88%). In Australia, in2009 (Australia's Mothers and Babies, AIHW, 2011) the overall rate of preterm birth (birth before 37 weeks) amongst women with twins was 52.2%.[5]

More than half of the babies were delivered preterm [83.3%] which was higher than Hashimoto et al and other series (29%-54%). This higher incidence could be due to a higher rate of preterm termination, as we had 16.6% patients with GHTN of all twin pregnancies, 2084 (89.5%) were diagnosed before 19 weeks of gestation (65.2% before 13 weeks), with no significant change over the 5 years. - S.V. Glinianaia et al.

By comparing parity with multifetal gestation, Azubike et al in Nigeria during the year 1982 showed that as Parity advances, the incidence of twins increases from 2% in Primi to 6.6 % in multiparous women. But, in my study [Table 3], Primi gravida had more number of multiple Pregnancies [67.4%] than multi gravida [32.5%].

Multiple pregnancies with complications are referred from many private hospitals for better management. Comparable incidence was seen in studies done by Bangal et al (1.49%) and a study done in Sheikh Muji Medical University, Dhaka. Studies by Assuncao et al conducted in 289 twin pregnancies between 2003 to 2006 it was found that 60% were DCDA, 30.8% were MCDA and 6.6% were MCMA. But in our study, the incidence of Monochorionic gestation was higher (51.58%) with MCDA-49.2% and MCMA-2.38%when compared to Dichorionic (46.8%) and Trichorionic (1.58%) gestation. There was no maternal mortality in our study.[7]

The incidence of having a baby with low birth weight in our study was (of less than 2 kg) was 90.4% for baby 1, 91.26% for baby 2 and 100% for baby 3; however, Bangal et al showed an incidence of 82%. Babies with birth weight less than 2.5 kgs were found to occur at a higher rate in monochorionic [51.06%] than in dichorionic [41.5%] and trichorionic [2.46%] pregnancies.

In our study, there was only one case with APH. Similar incidence of APH was seen (2%) by Yuel Veronica et al. This was contrary to findings of many researchers who have found significant association between APH and multiple pregnancies. There was 1.36 times higher risk of APH in multiple pregnancies as compared to singleton group. Olusanya reported 1-2l fold increased risk in twin which was slightly higher a than risk observed in present pregnancy and reported by Abasiattai AM and Sultana M et al. The difference in the risk of antepartum haemorrhage between studies could be explained by the difference in risk factors for antepartum haemorrhage between the studies populations. As per table no 4 and 5,there was no significance in mode of conception and family history of multiple pregnancy in relation to chorionicity. Adesina K T et at, sultana masuda et al also reportedsimilar perinatal mortality rate [Ref.No-3]. Naushaba et al showed that most common cause of neonatal death was low birth weight (32.8%) cases, but in my study, the most common cause being respiratory distress [39.2%] and Perinatal asphyxia [39.2%].[9]

In our study Out of the monochorionic pregnancies, congenital anomalies were present in 4.6 % of cases and nil cases in dichorionic and trichorionic pregnancies. The incidence of congenital anomalies were more in monochorionic pregnancies similar to the results shown by S.V. Glinianaia et al who showed that congenital anomalies were twice as common in monochorionic pregnancies.[6]

By analysing APGAR score and choronicity, a 5 minute APGAR score of less than 7 was found in 13% of monochorionic,4.06% of dichorionic,1.62% of trichorionic pregnancy in baby 1; 5.08% in monochorionic, 0.8 % in both dichorionic and trichorionic pregnancies in baby 2 and in baby 3, both had APGAR score of less than 5. The apgar score was found to be less in monochorionic pregnancies [18.08%] than in dichorionic pregnancies [4.86%] similar to the study results of Naushaba et al.[4]

In my study, discordant growth was found in 2.8% of monochorionic 1.6% of dichorionic and 0.1% of trichorionic pregnancies. Discordancy was more in monochorionic pregnancies [2.8%] similar to the results of Domonigues et al. Of the maternal l ante natal complications, GHTN ranked first which was found in 16.6% [Table 7] and next to that is anemia [7.9%].

As per table no 28,causes for neonatal morbidity like RDS was present in 84.1% of monochorionic , 65.8 % of dichorionic and 100% in trichorionic pregnancies., LBW was present in 71.6 % of monochorionic, 71.7% of dichorionic,16.6% in trichorionic pregnancies., VLBW in 40% of monochorionic, 20.5% of dichorionic,83.3% in trichorionic pregnancies., birth asphyxia in 8.3% of monochorionic and 4.2%,NNH in 13.3% monochorionic and 16.2% of dichorionic, Pulmonary

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haemorrhage in 1.6 % of monochorionic, Nil cases in dichorionic, Sepsis in 5% of monochorionic,11.1% of dichorionic, Intraventriculat haemorrhage in 2.5% of monochorionic, 0.8% of dichorionic,16.6% in trichorionic, HypoxicIschemic encephalopathy in 1.6% of monochorionic and nil cases in dichorionic and trichorionic gestation .The most common cause for morbidity was determined as Respiratory distress syndrome due to prematurity. All the complications were found to occurat ahigher ratein Monochorionic pregnancies as in the study by Dominigues et al.[10]

By analyzing Neonatal mortality with chorionicity, it was found in 21 cases of monochorionic [8.6%] and 7 cases of dichorionic [2.8%] and 2 cases of trichorionic [0.82%] pregnancies. This was comparable to the study results of Summera Alsam et al.[8] Adesina K T et at, sultana masuda et al also reported similar perinatal mortality rate. Naushaba et al showed that most common cause of neonatal death was low birth weight in (32.8%) cases. But in my study, out of neonatal deaths, Respiratory distress constituted for 34.7% in Monochorionic, 42.8% in Dichorionic, 100% in Trichorionic; Perinatal asphyxia contributed for 30.4% in Monochorionic, 57.1% in Dichorionic,4.6% in Trichorionic, ICH for 13% in Monochorionic, Hypoxic Ischemic encephalopathy for 8.6% cases in Monochorionic, Pulmonary haemorrhage for 8.6% in Monochorionic gestation. The most common cause for death among both groups was Respiratory distress followed by Perinatal asphyxia in all monochorionic, dichorionic and trichorionic pregnancies.

The number of days in NICU was analysed and it was found that Monoichorionic deliveries had a longer duration of stay [32.1%] compared to Dichorionic [18.75%] for baby 1. For baby 2, it was 32.7 % for Monochorionic,26.3% for Dichorionic,1.8% for Trichorionic gestation. Both the babies 3 needed longer duration of stay in trichorionic gestation

In our study, 82.2% of babies were discharged alive and 17.8% of babies expired in monochorionic pregnancy .93% of babies were discharged alive and 7 % of babies expired indichorionic gestation. In trichorionic pregnancy, 33.3% of babies discharged and 33.3% of babies expired. The fetal outcomes in terms of NICU admission, number of babies discharged alive, number of babies expired, babies with less than APGAR score less than 7 showed statistical significance and more adverse outcomes in monochorionic than dichorionic and trichorionic pregnancy.

CONCLUSION

The incidence of maternal and fetal adverse outcome are increased significantly in multiple pregnancies.It is highly advisable to determine the chorionicity at 11-14 weeks of gestation as each type of placentation carries different prognosis and morbidity.

Monochorionic pregnancies are at increased risk of developing various complications and adverse perinatal outcome than dichorionic and trichorionic pregnancies. Assessment of chorionicity helps in the management of discordant growth, twin to twin transfusion, feasibility of multifetal reduction and management of other complications. Early diagnosis of chorionicity and proper follow up throughout the gestation improves the perinatal outcome. Regular ultrasound study for the growth and wellbeing of the twins particularly monochorionic twins is mandatory. Monochorionic pregnancies are at increased risk of developing congenital anomalies such as a cardiac twins.

Early detection and management of preterm, early referral to fetal medical centers in case if complication occurs and early hospitalization are the most important steps in improving perinatal Outcome and reducing adverse maternal out come in cases of multiple pregnancies. By determining the Placentation, we can counsel the patients regarding the risk of perinatal outcomes and invasive testing. Thorough intranatal and postnatal vigilance is required to lower the adverse outcome in multiple pregnancies. A better obstetric care, neonatal care and health services are needed to get a better fruitful outcome.

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